OAG
Office of the Auditor General

Report Summary

Performance Audit
Children's Protective Services (CPS) Investigations
Michigan Department of Health and Human Services (MDHHS)

Report Number:
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Michigan's Child Protection Law (CPL) requires that MDHHS investigate allegations of child abuse and/or neglect (CA/N). MDHHS's CPS investigators are responsible for conducting CPS field investigations in compliance with CPL and MDHHS policy requirements and taking appropriate action(s) to ensure the child's safety. Investigators are compelled to follow these requirements to help ensure that (1) allegations of CA/N are promptly and appropriately addressed, (2) the current safety and future risk of harm to a child are properly assessed, (3) appropriate protective interventions are put in place, and (4) preponderance of evidence conclusions are supported by a systematic and objective examination of facts and evidence. CPS investigators completed approximately 206,000 investigations between May 1, 2014 and July 31, 2016, and determined that a preponderance of evidence of CA/N existed in 26% of investigations.

Audit Objective	Conclusion
Objective #1: To assess the sufficiency of MDHHS's efforts to ensure the appropriate and consistent application of selected CPS investigation requirements.	Not sufficient

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not appropriately commence 17% of reviewed investigations within the CPL-required 24-hour time frame. MDHHS cited differences in interpretation of the law with the OAG regarding the requirement and application of MDHHS policy for over one-third of the exceptions noted (Finding #1).	X		Partially agrees
MDHHS could not support that investigators conducted Central Registry clearances for all required individuals in over 70% of the investigations reviewed (Finding #2).	X		Partially agrees
Investigators did not complete required criminal history checks for over 50% of the investigations reviewed (Finding #3).	X		Agrees
MDHHS could not support that investigators had conducted a complete CPS history review for family and household members in approximately 40% of the investigations reviewed (Finding #4).	X		Agrees

Findings Related to This Audit Objective (*Continued*)	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS could not support that the required contact with mandated reporters had occurred in over 30% of reviewed investigations. MDHHS also could not support that it provided the mandated reporter with written notification of MDHHS's disposition in nearly 70% of reviewed investigations (Finding #5).	X		Agrees
Investigators' face-to-face contact with alleged child victims was not within required time frames in 11% of reviewed investigations, averaging 6.4 days late (Finding #6).	X		Agrees
Investigators did not document required interviews of children, or the reason(s) why an interview was not conducted, in 7% of reviewed investigations. Investigators also did not document verification of the safety and whereabouts of all children in 13% of reviewed investigations (Finding #7).		X	Agrees
MDHHS could not support that initial safety planning had occurred or that it was not needed in 33% of reviewed investigations. Also, investigators' safety assessments were not complete or accurate for 7% of reviewed investigations and, on average, were not completed until 25 days after the initial contact with families (Finding #8).	X		Partially agrees
Required court petitions were not submitted by MDHHS in accordance with the CPL in 10% of reviewed investigations (Finding #9).	X		Agrees
MDHHS did not refer investigations to the county prosecuting attorney, as required, for 50% of reviewed investigations (Finding #10).	X		Agrees
Required sibling placement evaluations were not completed in 80% of the relevant investigations reviewed to document how a child remained safe in the perpetrator's care when another sibling(s) had been removed from the perpetrator's care (Finding #11).		X	Agrees
Required medical examinations of children were not obtained in over 15% of reviewed investigations, nor did MDHHS document the reasons why the medical examinations were not obtained (Finding #12).		X	Agrees
MDHHS did not accurately assess the risk of future harm to children in over 35% of reviewed investigations. These inaccuracies led to improper category classification and Central Registry omissions for 8 investigations in our sample (Finding #13).	X		Agrees
MDHHS did not conduct impact assessments for Michigan Statewide Automated Child Welfare Information System (MiSACWIS) risk assessment functionality changes. We identified over 6,000 previously completed investigations with incorrect risk levels and nearly 24,000 other investigations with potentially incorrect risk levels (Finding #14).	X		Agrees
Investigators did not complete required child and family needs and strengths assessments for nearly 20% of reviewed investigations (Finding #15).		X	Agrees

Findings Related to This Audit Objective (*Continued*)	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not complete nearly 30% of reviewed investigations within required time frames, ranging from 1 day to 8 months late and averaging 44 days late (Finding #16).	X		Agrees
Ineffective supervisory review of investigations significantly contributed to deficiencies reported in 15 findings, 11 of which are considered to be material conditions. Also, CPS supervisors did not review 18% of reviewed investigations within 14 calendar days and could not support that required case consultations occurred with investigators for 15% of reviewed investigations (Finding #17).	X		Agrees
MDHHS did not monitor families' participation in post-investigative services for nearly 22,000 investigations and therefore could not determine whether these families received and participated in the services intended to alleviate the child's risk level for CA/N (Finding #18).	X		Disagrees
Clarification of MDHHS policy and guidance provided to CPS investigators is needed for properly classifying investigations when MDHHS has filed a court petition and subsequent evidence does not support that CA/N occurred. Misclassification can impact Central Registry decisions, post-investigative service provision, and the accuracy of CPS history records (Finding #19).		X	Partially agrees
We identified 257 confirmed perpetrators of CA/N that MDHHS did not add to the Central Registry as required by the CPL (Finding #20).	X		Agrees
MDHHS could not support that it provided notification to perpetrators that their names had been added to the Central Registry for over 40% of reviewed investigations (Finding #21).	X		Agrees
Amendatory legislation is needed to add unlicensed Child Development and Care (CDC) Program child care providers to Section 8d(3) of the CPL to provide MDHHS with the statutory authority to include unlicensed CDC providers in the Central Registry when MDHHS identifies these individuals as perpetrators of CA/N in Category III CPS investigations (Finding #22).		X	Disagrees
CPS investigators were not required to complete an investigation checklist when conducting abbreviated CPS investigations, nor did MDHHS ensure that local county office directors always conducted a review of abbreviated investigations, when necessary, prior to closing the investigation (Finding #23).		X	Partially agrees

Observations Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
Our survey of CPS investigators indicated that a majority of the over 800 respondents had concerns regarding their physical safety while conducting CPS investigations (Observation #1).	Not applicable for observations.		
No statutory requirement exists for centralized oversight to ensure that an appropriate CA/N investigation protocol has been implemented in all Michigan counties (Observation #2).	Not applicable for observations.		
Standardizing commonly used policy terminology would increase MDHHS's assurance that CPS investigation requirements are carried out in a consistent, systematic, and objective manner (Observation #3).	Not applicable for observations.		

Audit Objective	Conclusion
Objective #2: To determine the effectiveness of MDHHS's efforts to accurately capture data used to report its compliance with selected CPS investigation timeliness requirements.	Moderately effective

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
MDHHS did not capture complete, accurate, and/or valid investigation commencement data for 26% of reviewed investigations (Finding #24).	X		Agrees

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